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RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

MEMORANDUM

September 2, 2018

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Opportunities to Improve Health Care"

On **Wednesday, September 5, 2018, at 10:00 a.m. in room 2123 of the Rayburn House Office Building**, the Subcommittee will hold a legislative hearing titled "Opportunities to Improve Health Care."

I. H.R. 3325, ADVANCING CARE FOR EXCEPTIONAL KIDS ACT

A. Background

Both Medicaid and the Children's Health Insurance Program (CHIP) play a critical role in providing coverage for children with medically complex conditions. Medicaid is the single largest insurer of children in the United States. Healthcare coverage for children insured by Medicaid is typically more comprehensive than other sources of coverage – particularly for children with disabilities – as all children in Medicaid are entitled to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Under this benefit, states are required to provide services that are determined to be medically necessary, even if the services are not listed as covered in the State Medicaid Plan.[1] For those services that are not listed in a state's State

[1] More information on the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is available online at (https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html).

Medicaid Plan, the state must contract with an in-state or out-of-state provider who will accept Medicaid payment.[2]

While there is not a single definition for children with medically complex conditions, in general, these children have chronic, multisystem diseases that are expected to last longer than a year, and that are associated with functional limitations, high morbidity and mortality, and high use of health resources.[3] Currently, there is limited data available on the number of children with medically complex conditions enrolled in Medicaid or the quality of care these children receive. One study estimated that 5.8 percent of the children covered by Medicaid in 2011 were children with complex medical conditions, and these children accounted for an estimated 34 percent of all Medicaid spending for children.[4]

Families with medically complex children often struggle with coordinating care across state lines. Pediatric specialists are better suited in many cases to treat medically complex children, however access to such specialists can be limited. As a result, children with medical complexity often must travel out-of-state to find providers to suit their unique care needs. Medicaid's very nature as a state-by-state program can make efficient coordination of care and payment particularly challenging. Stakeholders have noted that conflicting regulations and paperwork requirements can delay treatment and lead to unnecessary hospitalizations for medically complex children. Currently, states are permitted to contract with out-of-state providers for their Medicaid program, and the state must pay the out-of-state provider to the same extent that it would pay in-state providers for the same services.[5] However, not all specialists accept out-of-state Medicaid payments and providers who do, have reported significant delays in payment.

Providers also note delays in patient care due to additional screening and enrollment processes. Federal law requires that before a provider can treat Medicaid patients in a certain state they must undergo screening and subsequently enroll in a state's Medicaid program. The law also allows for states to rely on screening conducted by other state Medicaid programs or Medicare. In addition, in 2011 the Centers for Medicare and Medicaid Services (CMS) released guidance to avoid duplicative screening by encouraging states to collaborate in determining which states are to conduct required screening for providers seeking simultaneous enrollment in

[2] Centers for Medicare & Medicaid Services (CMS), *EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (June 2014) (online at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf).

[3] Joanna Thompson et al., *Financial and Social Hardships in Families of Children with Medical Complexity*, Journal of Pediatrics (May 2016).

[4] Jay G. Berry et al., *Children with Medical Complexity and Medicaid: Spending and Cost Savings*, Health Affairs (Dec. 2014).

[5] 42 CFR 431.52.

multiple state Medicaid programs.[6] Despite this, some states still require providers already screened and enrolled in one state Medicaid program to undergo additional screening before providing services in their own state's Medicaid program, or before the provider can receive payment for their services.

In recent years, states have been implementing new delivery system models for their Medicaid and CHIP programs to increase integration of services and care coordination and reward providers for these activities. For example, the Affordable Care Act established a Medicaid health home state option, under which a state may create health homes to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions.[7] As of April 2018, 22 states and the District of Columbia had approved 34 Medicaid health home models.[8] However, these models do not specifically address medically complex children and the unique multi-state and/or national care needs of this population.

B. Legislation

The AINS to H.R. 3325, the Advancing Care for Exceptional Kids Act (ACE Kids Act) introduced by Reps. Barton (R-TX) and Castor (D-FL), would establish a Medicaid health home state option specifically targeted for children with medically complex conditions. A state that takes up this option will receive a 90 percent enhanced Federal Medical Assistance Percentage (FMAP) for care coordination for the first eight fiscal year quarters the state plan amendment (SPA) is in effect. The AINS also requires the Secretary to issue guidance to state Medicaid programs regarding best practices for using out of state providers for children with medically complex conditions, coordinating care with out of state providers, reducing barriers to care from out of state providers, and processes for screening and enrolling out of state providers. States must demonstrate in their state plan amendment how they intend to improve care coordination and management and remove barriers to out of state care for children with medically complex conditions. The Subcommittee held a hearing on a discussion draft of this legislation on July 7, 2016.[9]

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[6] CMS, Center for Medicaid and CHIP Services, *Medicaid/CHIP Provider Screening and Enrollment* (Dec. 23, 2011) (https://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-23-11.pdf).

[7] Centers for Medicare and Medicaid Services (CMS), *Health Homes* (https://www.medicaid.gov/medicaid/ltss/health-homes/index.html).

[8] CMS, *Approved Medicaid Health Home State Plan Amendments* (April 2018) (https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-map.pdf).

[9] House Committee on Energy and Commerce, *Examining the Advancing Care for Exceptional Kids Act*, 114th Cong. (July 7, 2016) (https://democrats-energycommerce.house.gov/committee-activity/hearings/legislative-hearing-on-examining-the-advancing-care-for-exceptional-kids).

II. H.R. 3891, TO AMEND TITLE XIX OF THE SOCIAL SECURITY ACT TO CLARIFY THE AUTHORITY OF STATE MEDICAID FRAUD AND ABUSE CONTROL UNITS TO INVESTIGATE AND PROSECUTE CASES OF MEDICAID PATIENT ABUSE AND NEGLECT IN ANY SETTING, AND FOR OTHER PURPOSES

A. Background

Currently, 49 states and the District of Columbia operate Medicaid Fraud Control Units (MFCUs).[10] MFCUs investigate and prosecute provider fraud and patient abuse and neglect in the Medicaid program. Each state is required to have a MFCU unless they demonstrate to the Secretary that their Medicaid program has a minimal amount of Medicaid fraud and that beneficiaries are sufficiently protected from abuse and neglect. MFCUs must be operated by an entity independent from the state Medicaid agency and they typically operate as part of a state's Attorney General's office. The Department of Health & Human Services Office of the Inspector General (HHS OIG) is responsible for annual recertification of each MFCU as well as administering federal grants to fund a portion of the MFCUs' operational costs.[11] According to HHS OIG in 2017, MFCUs recovered a total of $1.8 billion, or a return on investment of $6.52 for every $1.00 spent by states and the federal government on operating MFCUs.[12]

Under current law, MFCUs may only investigate and prosecute Medicaid fraud and patient abuse and neglect in health care facilities and board and care facilities (i.e. institutional settings). However, in 2017 HHS OIG expressed support for expanding the authority of MFCUs to non-institutional settings in recognition of the growth in home and community-based services (HCBS), transportation services, and other services provided in non-institutional settings.

B. Legislation

H.R. 3891, introduced by Reps. Walberg (R-MI) and Welch (D-VT), would expand the authority of MFCUs to investigate and prosecute Medicaid fraud and beneficiary abuse and neglect in non-institutional settings or any other setting.

III. H.R. 5306, ENSURING MEDICAID PROVIDES OPPORTUNITIES FOR WIDESPREAD EQUITY, RESOURCES, AND CARE (EMPOWER Care) ACT

[10] North Dakota and the territories do not operate MFCUs. *See* National Association of Medicaid Fraud Control Units, *Medicaid Fraud Control Units* (http://www.namfcu.net/medicaid-fraud-control-units.php).

[11] Department of Health and Human Services, Office of Inspector General (HHS OIG) *Medicaid Fraud Control Units, MFCUs* (https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp).

[12] HHS OIG, *Medicaid Fraud Control Units Fiscal Year 2017 Annual Report* (March 2018) (https://oig.hhs.gov/oei/reports/oei-09-18-00180.pdf).

A. Background

The Money Follows the Person (MFP) Rebalancing Demonstration Grant was first authorized by the Deficit Reduction Act of 2005 and was later reauthorized through fiscal year (FY) 2016 by the Affordable Care Act.[13] While the grant program expired in 2016, states can continue to use any remaining grant funding through FY 2020. The program provides funding to states to help Medicaid beneficiaries receiving treatment in institutions transition to home and community-based care (i.e. "rebalance" care from institutional to non-institutional settings). Currently, 43 states and the District of Columbia participate in MFP and as of December 2016, about 75,000 individuals transitioned from institutions back into the community because of MFP programs.[14] Furthermore, MFP encourages states to institute programs that allow for funding for long-term services and supports (LTSS) to follow a beneficiary to their chosen care setting. According to the program's most recent evaluation, it is estimated that transitions through the end of 2013, generated health care cost savings in the range of $204 to $978 million.[15]

B. Legislation

H.R. 5306, the Ensuring Medicaid Provides Opportunities for Widespread Equity, Resources, and Care Act (EMPOWER Care Act) introduced by Reps. Guthrie (R-KY) and Dingell (D-MI), would reauthorize the Money Follows the Person (MFP) Rebalancing Demonstration Grant for five years at $450 million each year. The legislation would change the institutional residency period from 90 days to 60 days, therefore increasing the number of beneficiaries eligible for the program. It also requires the Secretary to submit a report to the President and Congress not later than September 30, 2020 detailing best practices from state MFP programs.

IV. H.R. ____, A DISCUSSION DRAFT TO PROHIBIT THE USE OF SO-CALLED "GAG CLAUSES" IN MEDICARE AND PRIVATE HEALTH INSURANCE PLANS

H.R. ____, prohibits any group health plan or health insurance issuer, as well as any Medicare Part D plan sponsor or Medicare Advantage organization from construing a policy or contract term to prevent pharmacists from informing consumers that their prescription could be purchased for a lower price if paid out-of-pocket instead of through their insurance plan. This bill increases consumer transparency and understanding by informing patients that they can obtain their prescriptions for a lower cost in some cases than under their insurance plan's cost-sharing allocations, and promotes consumer understanding that they may save money by choosing to pay

[13] CMS, *Money Follows the Person* (https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html).

[14] *Id.*

[15] Mathematica, *Money Follows the Person 2015 Annual Evaluation Report* (May 11, 2017) (https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-2015-annual-report.pdf).

out-of-pocket instead. This bill would be effective for plan years beginning on or after January 1, 2020.

V. H.R. _____, A DISCUSSION DRAFT TO CODIFY THE HEALTH FRAUD PREVENTION PARTNERSHIP (HFPP)

H.R. _____, codifies the Health Fraud Prevention Partnership (HFPP), a public-private partnership between the federal government, law enforcement, state health agencies, private health insurance plans, and health care anti-fraud associations. HFPP exchanges data and information between the partners in order to combat fraud, waste, and abuse in the health care sector. Eighty-five public, private, and state organizations participated in HFPP in FY2017.

This bill authorizes the HFPP and ensures adequate transparency requirements are in place to enable HFPP to fulfill its mission.

VI. WITNESSES

Rick Merrill
President and CEO
Cook Children's Health Care System

Derek Schmidt
Attorney General
State of Kansas

Matt Salo
Executive Director
National Association of Medicaid Directors

Curtis Cunningham
Vice President
National Association of States United for Aging and Disabilities

Hugh Chancy
CEO, Chancy Drugs
On Behalf of the National Community Pharmacists Association (NCPA)

David Yoder
Executive Director, Member Care and Benefits
Blue Cross Blue Shield Association's Federal Employee Plan (BCBSA FEP)